UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

MICHAEL ANGELO,

Plaintiff,

-v- Case No. 19-12165

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, et al.,

Defendant.
_____/

MOTION HEARING

BEFORE THE HONORABLE **DENISE PAGE HOOD**
United States District Judge
Theodore Levin United States Courthouse
231 West Lafayette Boulevard
Detroit, Michigan
December 7, 2022

APPEARANCES:

FOR THE PLAINTIFF:
Shereef H. Akeel
Samuel R. Simkins
Akeel & Valentine, Plc
888 W. Big Beaver, Suite 420
Troy, MI 48084

John William Cleary, Jr.
Ryan Hy Susman
MSP Recovery Law Firm
2701 S. LeJeune Rd., Suite 10th Floor
Miami, FL 33134

Jose Alfredo Armas
Armas Bertran Pieri
4960 SW 72 Ave., Suite 206
Miami, FL 33155

FOR THE DEFENDANTS:
Bryce L. Friedman
Kathryn Wheelock
Simpson Thacher & Bartlett LLP
425 Lexington Avenue
New York, NY 10017

APPEARANCES CONTINUED FOR THE DEFENDANTS:

Emily Newton
King & Spalding
1180 Peachtree St. NE
Suite 1600
Atlanta, GA 30309

Jordan S. Bolton
Clark Hill PLC
151 S. Old Woodward Ave.
Suite 200
Birmingham, MI 48009

Douglas W. Baruch
Morgan, Lewis & Bockius LLP
1111 Pennsylvania Ave, NW
Washington DC, DC 20004

Robert C. Folland
Barnes & Thornburg LLP
41 South High Street
Suite 3300
Columbus, OH 43215

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2:04 p.m.

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CASE MANAGER: All rise.

United States District Court for the Eastern District of Michigan is now in session. The Honorable Denise Page Hood presiding.

You may be seated.

Calling Case Number 19-12165, Michael Angelo and MSP WB, LLC, et al., versus State Farm Mutual Automobile Insurance Company, et al.

Counsel, please place your appearances on the record.

MR. ARMAS: Good afternoon, Judge. May it please the Court, Alfredo Armas of Armas, Bertran, Zincone, on behalf of the relators, Michael Angelo, and MSP Recovery WB.

THE COURT: Okay. Good afternoon to you.

Who is with you? Oh, everyone's going to speak. Okay.

MR. ARMAS: Judge, if you want, this is John Cleary from MSP Recovery Law Firm, and to his right is my friend Shereef Akeel of Akeel & Valentine, who is also co-counsel for the relators.

THE COURT: Okay.

MR. AKEEL: Good afternoon, Judge.

MR. CLEARY: Good afternoon.

THE COURT: Good afternoon. How are you? How are both of you?

MR. CLEARY: Good, Your Honor.

THE COURT: Good.

Thank you. Counsel.

And for the defendants.

MR. FRIEDMAN: Good afternoon, Your Honor. My name is Bryce Friedman. My firm is Simpson, Thacher, and Bartlett. We represent the Travelers defendants and the Berkshire Hathaway defendants. With me is my colleague, Kate Wheelock. We will be addressing the Court in support of a motion to dismiss on behalf of all the defendants.

THE COURT: Okay.

Ms. Wheelock, is it common spelling of Wheelock?

Ms. WHEELOCK: I'm not sure what the common spelling is, Your Honor, but it's W-h-e-e-l-o-c-k.

THE COURT: Yeah, common spelling. Thank you.

MS. WHEELOCK: Great. Thank you, Your Honor.

THE COURT: All right. Your firm has an appearance filed?

MR. FRIEDMAN: Yes, Your Honor.

THE COURT: Okay. Which would include her; is that correct?

MR. FRIEDMAN: That is correct.

THE COURT: Okay. And you're not expecting -- are any other counsel here?

MS. NEWTON: Good afternoon, Your Honor. I'm Emily Newton from the Law Firm of King and Spalding. I represent the Progressive defendants --

THE COURT: Okay.

MS. NEWTON: -- and also Auto Club. With me is Jordan Bolton from Clark Hill.

THE COURT: Jordan Bolton?

Ms. Newton: Yes.

MR. BOLTON: Good afternoon, Your Honor.

THE COURT: Okay. Good afternoon to both of you.

And for State Farm?

MR. BARUCH: Good afternoon, Your Honor. Doug Baruch from Morgan, Lewis on behalf of State Farm.

THE COURT: Okay. Good afternoon.

And one more. Robert Folland.

MR. FOLLAND: Yes. Afternoon, Your Honor. Robert Folland from Barnes and Thornburg on behalf of ISO, which stands for Insurance Services Office.

THE COURT: Okay. There wasn't room for you up front?

MR. FOLLAND: I'm happy to move up right now, Your Honor.

THE COURT: Okay. Anybody else? No?

Okay. Is there room? I think there's room, isn't there?

MR. ARMAS: Judge, we have room over here for Mr. Folland.

THE COURT: What are you -- do you need one more chair over there? No? Are you okay? Okay. You're okay?

MR. FOLLAND: Yes.

THE COURT: All right.

Okay. This is the defendants' motion to dismiss the amended complaint, and there are a few other motions to dismiss as well. And I think you've organized yourselves relative to my request, that you organize to make oral arguments; is that right?

MR. FRIEDMAN: That's correct, Your Honor.

Bryce Friedman again from Simpson Thacher. I'll be presenting the main argument on behalf of the defendants.

THE COURT: Okay. Very good.

Okay.

MR. ARMAS: Judge, if I may. On behalf of the relators and co-relators, Mr. Akeel will be addressing any discrete issues regarding the State Farm/Michael Angelo dispute, which is pending in front of Judge Cleland and the Sixth Circuit Court of Appeals.

THE COURT: Okay. All right.

And then, are there other people arguing also? I

have that you're making an argument. Is Mr. Cleary making an argument?

MR. ARMAS: Mr. Cleary will not, Judge, he will assist me.

THE COURT: Okay. What does that mean? He's not going to orally make a presentation?

MR. ARMAS: That's correct, Judge.

THE COURT: Okay. But I think what you're telling me is that Mr. Akeel is going to make an oral presentation?

MR. ARMAS: That is correct, Judge.

THE COURT: Okay. Will you be making the first response?

MR. ARMAS: Yes, I will.

THE COURT: Okay. All right. Then, let's proceed.

But I would like you to go to the microphone if you don't mind.

MR. FRIEDMAN: Good afternoon, again, Your Honor.

THE COURT: Good afternoon.

MR. FRIEDMAN: May it please the Court, again my name is Bryce Friedman, on behalf of the Travelers defendants, the Berkshire Hathaway defendants. And again, I'm going to be arguing the omnibus motion to dismiss on behalf of all of the defendants.

This is a case alleging violations of the False Claims Act by more than 300 insurance companies. Plaintiffs

purport to bring this case on behalf of the U.S. Government, a number of states, and Puerto RICO. Not one of those governments has chosen to intervene in this case, or objected to dismissal.

The thrust of the complaint in this case is an assertion that defendants failed to report liability insurance coverage to Medicare, and that eventually deprived some private health insurers of money.

I intend to focus my time on the argument that the complaint should be dismissed as a matter of law. I won't repeat what's in the substantial papers that have been filed, but I will get, or try to get to the heart of the very disputed issues.

There are a number of ancillary motions related to taking judicial notice of certain documents, motions to strike, request to supplement the record, and the like. I plan on addressing those only briefly and in passing, to the extent necessary, as part of my substantive argument unless the Court has a different preference.

And to the extent the Court has what I would consider to be specific and detailed questions about those issues, Ms. Wheelock is here to address them.

So I will proceed to my argument as to why the complaint should be dismissed, for two reasons. And, of course, I welcome Your Honor's directions or questions along

the way.

THE COURT: Okay. Thank you.

MR. FRIEDMAN: First, the complaint fails to plead the elements of the False Claims Act violations as required by Rules 8 and 9(b).

Second, the Court should dismiss the case pursuant to the False Claims Act public disclosure bar set forth in Section 3730(e)(4), Title 31 of the U.S. Code.

We've recently submitted a notice of supplemental authority to the Court, to make Your Honor aware of Judge Murphy's decision in an almost identical case against a group of insurers under the Allstate banner. That's civil Case Number 19-11615.

Judge Murphy dismissed the substantive False Claims Act counts against Allstate based on the public disclosure bar, which is the same grounds that the defendants in this case have moved on against a virtually identical complaint. The same public disclosure bar reasoning applies with equal force here.

So with the Court's indulgence, I will begin my argument with the public disclosure bar. Section 3730(e)(4)(A), says that, quote, "The Court shall dismiss an action substan -- an action when it's based on substantially the same allegations or transactions as alleged in the action or claim where publicly disclosed."

I butchered that. I apologize.

Relevant to this case, the public disclosure bar applies where the disclosure is: (1) in a federal hearing where its government or its agent is a party; or (2) in the news media.

Here, substantially the same industry wide allegations of a scheme not to report liability insurance to Medicare were publicly disclosed, starting at least eight years ago in two other cases brought under the False Claims Act. One that I'm going to call Hayes, and the second that I'm going to call Takemoto. There's also a series of news articles reporting on those cases and the fraudulent scheme alleged in those cases and these cases that are the subject of our request for judicial notice.

The public complaint that we say is a disclosure in the Hayes case is found at ECF 339-37. The public complaint in the Takemoto case is found at ECF 339-36. And the news article I may discuss, which reports on same, is found at ECF 339-29.

The Hayes and Takemoto cases like this one, alleged an industry-wide scheme by insurers, and their service providers to underreport liability insurance to Medicare. Thereby, reducing insurance companies' obligations to private health insurers that contract with Medicare.

The key statutory inquiry for purposes of the public

disclosure bar is whether the prior complaints put the Government on notice of the alleged fraud that is asserted in this case before Your Honor. Takemoto and Hayes did just that.

The three complaints, Hayes, Takemoto and this one, are substantially the same for purposes of the public disclosure bar. And therefore, respectfully, the Court is required -- shall dismiss according to the statute. The substantially same standard is located in the statutory text and discussed at length in the Sixth -- by the Sixth Circuit in a case called U.S. ex rel. Maur, M-a-u-r, 981 F.3d 516. That's from 2020.

Now, the public disclosure bar applies because Takemoto and Hayes complaints are stantially -- substantially the same as this one. All three allege a scheme to underreport liability insurance to Medicare.

There need not be an identity of allegations. There need not be an identity of allegations, even as to time, place, and manner, to trigger the public disclosure bar once the Government knows the essential facts of a scheme and has enough information to discovery related frauds.

Judge Murphy's Allstate opinion does a thorough job of explaining exactly why the Takemoto's and Hayes' complaints are public disclosures, and are substantially the same as the complaint here. He said, quote, "It is hard to imagine facts

that more closely align with the relators' allegation than what Takemoto entail." End quote.

So I'm not going to redo what Judge Murphy did, and I'll be brief. I'm just going to focus on relators' arguments, the plaintiffs in this case, I'll sometimes call relators, why their complaint is different than the public disclosures.

Page 10 of relators' opposition, ECF 376, page ID 3905, summarizes in bullets, the substance of the allegations of its complaint, and why it thinks it's somehow different.

The first bullet talks about the willful failure to report to Medicare, and this is why they think they're different, after specific notice from the relators. In other words, these relators said they went and told the defendants, you guys got to do a better job of complying with Medicare.

But as Judge Murphy found on page 23 of his Allstate opinion, that allegation is nearly identical to a claim in Takemoto, which says, quote, "Defendants were aware of their obligations to make payments, both due to the well-established nature of the statute, and because Dr. Takemoto repeatedly contacted defendants and provided them with a detailed explanation of their rights and liabilities under the statute."

It's practically identical, what these relators say and what was said in the Takemoto case. This shows that

Takemoto disclosed the exact theory of fraud that the relators in this case say make this case unique.

The second and third bullet points on page 10 of relators' brief talk again, about the willful failure to report. And they say they're special and different in this case, because they have certain exemplars that contain specific information. And they say just in broad strokes that there were lots and lots of other instances.

Well, in Rahimi, which is the Sixth Circuit decision from 2020, and I'll provide the cite in a minute, the Sixth Circuit said, quote, "A relator's claims cannot survive the public disclosure bar because his allegations added some new details to describe, essentially, the same scheme by the same corporate actor as the publicly disclosed fraud."

Hayes and Takemoto alleged the same scheme in that case as is alleged in this case. Hayes alleged, quote, "A national corporate practice as well as an industry-wide scheme."

In paragraph 71 of Hayes' complaint, he said, quote, "This scheme of avoiding, advising, or notifying Medicare as well as avoiding reimbursing Medicare was fine-tuned by the entire liability industry."

Not only that, but Hayes also disclosed specific examples by name of the company and the particular claim, and the individual employees who were allegedly involved with the

specific examples.

In paragraph 70 of Hayes' complaint, for example, and I don't mean to pick on somebody, he made allegations against the Geico defendants in Berkshire Hathaway. Again, names, dates, names of employees.

Paragraph 251 of Hayes, he made specific similar allegations against my client, Travelers. There's a whole list in Exhibit C to the Hayes complaint at RJN 339-37.

Takemoto also alleged a wide rating scheme that resulted in a large number of underreports. Judge Murphy summarized this at page 27 of his decision, and I'm not going to go through and repeat that summary.

Suffice it to say, that relators' allegations in the complaint, before the Court here, repeat the same story as Hayes and Takemoto, that primary payers failed to create and enforce the system identifying when their insurers were covered by Medicare, which led to underreporting. Here, they claim they're different because they came up with a bunch of specific examples that I'll discuss in a minute. But that's why they claim they're different.

But the Sixth Circuit in Rahimi said just adding new examples doesn't make you different and take you outside the public disclosure bar.

Okay. So here's the last big difference in the bullet points that relators provide. Which is, that they

claim correctly, that in their complaint, there is a defendant named ISO, capital I, capital S, capital O, which stands for Insurance Services Office. And cap -- the Insurance Services Office was not a defendant in Hayes or Takemoto. That's correct. However, that doesn't change the public disclosure analysis, for a bunch of reasons.

First of all, as we'll get to in a second, the adding defendants, just like adding details, when you allege in an industry-wide scheme, doesn't matter for purposes of the public disclosure bar, when the government is on notice of the alleged fraud.

And in the Takemoto case, there were two entities that were exactly like ISO, for purposes of the discussion here, of the public disclosure bar.

Paragraphs 22, there's an entity in Takemoto called Sedgwick Claims Management. Paragraph 23, there's an entity called BroadSpire. Just like ISO, they are not insurance companies. They provide services to insurance companies. Just because in one case you name Adam, and the next case you name Bill, that doesn't take you outside of the public disclosure bar.

In Maur, M-a-u-r, the Sixth Circuit says, once the Government knows the essential facts of a scheme, it has enough information to discover related frauds.

The addition of ISO to this complaint does not

remember -- render it any different than Hayes or Takemoto.

Based on the filing the relators did last night, in which they provided the Court a bunch of charts about who was in and who was out, I suspect they're going to argue, well, not every defendant in this case was a defendant in Hayes or Takemoto. Well, in Takemoto, there were 56 defendants and 20 insurer groups. In Hayes, there were 45 defendants and 18 insurer groups. And here, there are 15 defendants -- defendant groups and 317 defendants. Ten of the 15 defendant groups overlap with those in Hayes or Takemoto.

But most importantly, for purposes of this, remember, please, Hayes and Takemoto were about an alleged industry-wide fraudulent scheme. Industry wide allegations appears 22 times in the Hayes complaint. Paragraph 382 of the Hayes complaint is just one example describe -- describing an industry-wide scheme.

I submit the law settled on this point, that identifying different defendants, whether they're corporate affiliates, service providers, different members of the same industry, does not rescue a complaint from the public disclosure bar. What matters is that the alleged fraudulent scheme is the same.

Here's a quote again from Maur, 981 F.3d 526. Quote, "It also does not matter that Maur, the relator in that case, has added another Tennova subsidiary, Tennova was the

defendant, its parent and Corbin, a service provider, as additional defendants. That's what the Sixth Circuit said. It doesn't matter that all these random people got added. Because the Government knew the essential facts of a scheme, it had enough information to go out there and discover related frauds.

Also important, in the Holloway case from the Sixth Circuit, 2020. I'll give you a full cite in a second. The Sixth favorably cited the seventh decision in Gear, g-e-a-r, which is the sort of seminal case on the point that alleged industry-wide fraud is enough to put the Government on notice. And an additional complaint that identifies other industry members and other examples of the same alleged fraud is not enough to avoid the public disclosure bar.

Now, I just want to touch on something briefly related to the public disclosure bar that Judge Murphy did not reach in his case, which is the conspiracy count. Which is Count Two of the complaint in this case.

In addition to substantive violations of -- or so-called reverse false claims, the relators here say there was a grand conspiracy among all 317 defendants to -- to violate the act. I'll get to the quality of those allegations shortly.

But I want to make the point clear, that the Court can dismiss and should dismiss the conspiracy count based on

the public disclosure bar as well. In addition to the substantive violations, which were dismissed as Judge Murphy did. Judge Murphy just said he was going to get to the conspiracy count later in an additional order, and he hasn't done so as of today, to my knowledge.

So in U.S. versus Walmart, 858 Federal Appendix 876, from 2021, the Sixth Circuit said, quote, "Conspiracy under the FCA, meaning the False Claims Act, is derivative of the substantive claims." End quote.

Therefore, public disclosure of the allegedly fraudulent scheme by the industry is sufficient to put the Government on notice of the alleged conspiracy to accomplish this scheme, and is substantially the same allegation of fraud.

In other words, if the Government knew of the industry-wide scheme, knowledge of an agreement among industry members is substantially the same, and would not materially add to the disclosed allegation.

And there are two cases that were relatively recently decided from courts in the Second Circuit that are not cited in our briefs, that specifically address this issue. And I would like to just cite them for the Court. U.S. ex rel. CDK 551 F.3d 27, from the Southern District of New York. And Patriarca, P-a-t-r-i-a-r-c-a versus Siemens Health Care, S-i-e-m-e-n-s, 295 F.3d 186, from the Eastern District of New

York.

Those cases are two recent examples where the Court looked at conspiracy counts concerning the same fraud that was publicly disclosed, and said that -- and said correctly, that the conspiracy count merely provides color to the primary violation that has been publicly disclosed. The same thing that is going on here.

Now, I'm going to just take a deep breath for one second, and I would like to quickly run through the issue of the sort of nits and nats that the relators raised to suggest that the public disclosure bar doesn't apply. And then, I'd like to hopefully spend just a few minutes discussing Rule 9(b), if Your Honor has the patience for me.

First, the relators argue that you can't address the public disclosure bar under Rule 12(B)(6) motion, like we have now. The relators are plainly wrong about that.

The statute says in no uncertain terms, that the Court shall dismiss an action when the public disclosure bar applies. Defendants have raised the public disclosure bar in Rule -- Rule 12 motions. Relators' contention that the public disclosure bar is an affirmative offense, and therefore can't be raised at the motion to dismiss stage is simply a false dichotomy.

Just because something can be an affirmative defense doesn't mean it can't be raised by Rule 12 motion. And I

think the -- the lack of merits to this contention is proven by the fact that all the Sixth Circuit cases cited by both sides dismiss cases based on the public disclosure bar in response to -- in response to Rule 12(B)(6).

Every case also -- every case that the parties have cited also take judicial notice of prior False Claims Act cases. Every case the parties have cited also take judicial notice of news articles. That's all I'm going to say about those two points here. I think they're relatively non-controversial in the case law. Case books are filled with False Claims Act cases applying the public disclosure bar based on prior federal complaints and prior news articles. Even if you have to pay to get the news article the same way you have to get a -- pay to get the Wall Street Journal, the New York Times, or the Detroit paper.

The next sort of nit or nat that the Government -- that the relators argue is that the complaints in Hayes and Takemoto can't be considered because the Government wasn't a party. Because just like the relators here, Hayes and Takemoto filed the lawsuits themselves, and the Government didn't care to intervene.

The Sixth Circuit decision in Holloway, at page 845 forecloses that argument. The Sixth Circuit said we are persuaded by the majority of district courts and our own districts court's reasoning, and hold that the qui tam relator

is in all cases, the Government's agent under 3730(e)(4)(A)(1), end quote.

The next argument the relators made is that the Court can't consider Hayes or Takemoto because neither of those cases survived the Rule 12 motion. And they were too vague and unclear to -- to be a prior public disclosure. That's wrong for a whole bunch of reasons. But I'll just start out by saying they were no more vague or unclear than the complaint here.

First, the statutory text of the False Claims Act requires the Court to dismiss based on a public disclosure. It doesn't limit the dismissal mandate in any way, shape, or form, to complaints in prior litigations that survived the motion to dismiss. This Court should reject the invitation to read words into the public disclosure bar that are not there.

Second, relator's position doesn't make any sense if you consider the purpose of the statute, which is to bar so-called parasitic lawsuits. One's based on information known or knowable to the Government.

Every qui tam lawsuit that comes with a disclosure statement, whether it passes a Rule 12 dismissal or not, it is made known to the Government.

If you think about the statute -- if you think about the statute for a second, if a news article is enough to trigger the public disclosure bar, which is what the statute

says, news articles don't have to pass Rule 12. So the idea that there's some special rule that applies to complaints having to pass Rule 12 doesn't make any sense.

The relators rely on a single case from the Sixth Circuit called Walburn, capital W, -a-l-b-u-r-n. With due respect to my adversaries, I think that's a misleading citation. Walburn is not a public disclosure bar case. It is a first-to-file bar case in an entirely different part of the statute that is not being raised by defendants here. The fact is, there is no authority in the Sixth Circuit that has been cited for the proposition that the public disclosure bar only extends to cases that survive a motion to dismiss.

So again, I -- I'm going to refer the Court to Holloway. And this time, I'll provide the citation, 960 F.3d 836. It's a Sixth Circuit, in 2020. The Sixth Circuit applied the public disclosure bar to a bunch of complaints that had been dismissed under the False Claims Act.

THE COURT: Okay. Give the citation again.

MR. FRIEDMAN: It is -- the name of the case is Holloway.

THE COURT: Right.

MR. FRIEDMAN: 960 F.3d 836, and it's from 2020.

THE COURT: Okay. Thank you.

MR. FRIEDMAN: The next miscellaneous argument that's been made is that the Hayes and Takemoto complaints are stale,

they're too old. Again, read the text of the statute. The False Claims Act statute does not say that the public disclosure bar must have been recent, or within a certain amount of time. It is entirely unqualified. And the purpose of the statute is not consistent with having a time limitation. If the Government knows, the Government knows. Sometimes the wheels of government spins slowly, but the Government knows.

Again, in Holloway, the Sixth Circuit applied the public disclosure bar to actions that had been dismissed a decade earlier. Even though they were ten years old, the disclosure in those complaints to the Government barred the case.

The last ground is -- that the plaintiffs rely on, the relators rely on, is an actual exception to the public disclosure bar that is in the statute. And that is, the public disclosure bar does not apply if the relators are, quote, "an original source," end quote.

An original source is defined in the statute as one of two things. One or A, someone who, prior to a public disclosure, has voluntarily disclosed to the Government, the information on which the allegations or transactions in a claim are based. So we can take that one off the table because I don't even think the relators claim that prior to Hayes or Takemoto, they disclosed anything to anyone.

So the exception that the relators are relying on is that they are -- they believe they are someone who has knowledge that is independent of, and materially adds to the publicly disclosed allegations or transactions, and that they voluntarily provided that information to the Government before filing this lawsuit that brings us here today.

Taking the complaint -- well, let me just say this.

The relators in this case do not satisfy the original source test. They do not have independent knowledge that materially adds to Hayes or Takemoto that they brought to the Government before filing the complaint.

So they will say that their exemplars add -- materially add to the knowledge about the publicly disclosed fraud. For this one, I will point to what Judge Murphy said, which is that the exemplars barely elaborate on the schemes disclosed in Hayes and Takemoto. And in any event, this matter and this argument that they make is controlled by the Sixth Circuit 2021 precedent in Rahimi versus Rite-Aid, which I've already cited, and the 2021 precedent in Maur, M-a-u-r, which I've already recited.

In Rahimi, the Sixth Circuit said, quote, "Offering specific examples of the alleged fraud does not provide any significant new information where the underlying conduct has already been disclosed." End quote.

That's at pages 831 to 832 of the Rahimi decision, 3

F.4th.

The Sixth Circuit went on. "Even though Rahimi was able to add state specific information and examples of government beneficiaries paying more, offering specific examples of the alleged fraud does not provide any significant new information where the underlying conduct has already been disclosed.

Rahimi's original input consists solely of putting more flesh on the fraud scheme of which the bones were already public. It would be contrary to the purpose of the act to extend the original source exception to such activities." End quote.

The same conclusion applies here. At best, reading the complaint here most generously, Angelo and MSP WB have alleged additional examples of alleged fraud. That is not enough to make either of them an original source.

Relators' counsel is going to stand up and emphasize that the way relators acquired these new examples was unique to an affiliate of relator MSP WB.

You're going to hear a lot about proprietary computer systems that can allegedly detect violations of the Medicare Secondary Payer Act, and you're going to hear about a hundred different lawsuits under the Medicare Secondary Payer Act that allegedly support this system. None of that matters for this False Claims Act case.

Hayes and Takemoto allege they saw the same fraud with their own eyes. That relators here are going to say, well, they didn't use their eyes, they used the computers that they're sitting behind. It doesn't mean that they've done anything other than add additional examples to a scheme that was already publicly disclosed.

And lastly on this point, I'll note, Judge Murphy thought it significant to the original source analysis that the information these relators have, came from a non-party. And that's sort of against the idea or the plain meaning of the very simple words, original source.

He felt, and I agree, that the commonsense concept doesn't apply in this circumstance because they got the information from non-parties who aren't even sitting here. And Judge Murphy cited some Tenth Circuit authority to support his view on that -- on that fact.

So with that, I will conclude the public disclosure argument by saying, the public disclosure bar clearly applies because the complaint in this case is substantially the same, and that it alleges substantially the same fraud as the complaints in Hayes and Takemoto and the news articles that describe that.

Relators are not entitled to the exception as an original source because they don't have independent knowledge that materially changes the game. All they have at -- taking

them at their word is some additional examples. And the Sixth Circuit has made crystal clear, additional examples are not enough.

So if the Court will indulge me for just a few more minutes, I just want to say a few things about Rule 9(b) and Rule 8 because I think they're particularly important. And I'd like to highlight some things that may not have came out -- jumped off the page in the mountain that we've provided you.

This is a False Claims Act case. And I think it's important to remember when the Court thinks about this case, that it is not a case about regulatory violations that have been alleged.

In a widely quoted opinion, the Fifth Circuit said, the False Claims Act is not a generalized enforcement of vice for federal statutes, regulations, and contracts.

We are here today, talking about fraud. The Fifth Circuit case is the Steury case, S-t-e-u-r-y, 625 F.3rd 262.

So the Sixth Circuit has been crystal clear about this, United States ex rel. Owsley, O-w-s-l-e-y, versus Fazzi, F-a-z-z-i, 18 F.4th 192, 2021.

The identification of at least one false claim with specificity is an indispensable element of a complaint that alleges a False Claims Act violation.

Our circuit, this is the Sixth Circuit speaking, has

opposed -- imposed a clear and unequivocal requirement that a relator allege specific false claims when pleading a violation of the act, thus under Rule 9(b), the identification of at least one false claim with specificity, is an indispensable element of a complaint that alleges false claims violations.

Rule 9(b) does not permit a False Claims Act Plaintiff merely to describe a private scheme in detail, but then simply allege that claims requesting payments must have been submitted. That means they have to have specific examples of false claims for each of the 317 defendants. They do not.

They're -- and if you -- there's the Branham case which was a Sixth Circuit 1999 case, 1999 West Law 618018, which makes it clear that the example needs to be for each defendant, as does the Second Circuit's opinion in Takemoto, the very case we've been talking about so far this afternoon.

Relators are going to stand up and say, we're entitled to a relaxed standard. We don't need to do a specific false claim, we're entitled to a relaxed standard. There is no relaxed standard. The Default Rule is that a False Claims Act claimant must identify a representative claim that was actually submitted to the Government for payment. That's what the Sixth Circuit said.

Then they said, alternatively, a claimant can otherwise allege facts based on personal knowledge, personal

knowledge with your own eyes, of billing practices supporting a strong inference that particular identified claims were submitted to the Government for payment. Relators have personal knowledge of nothing.

And let me tell you how strict that personal knowledge standard is. In the Owsley case, the one from '21, 2021, where the Sixth Circuit sat down this law, the relator, Owsley was a nurse, saw medical billers changing the diagnosis codes with her own eyes. She saw them adding new codes that were not supported by medical documentation. She personally touched and used those altered forms to complete her patient plans of care. And those forms, the next morning, were submitted to Medicare. The Sixth Circuit said that is not enough without a specific example of fraud.

Ms. Owsley is not sitting at the table over there. The relators have nothing near what Ms. Owsley had. In terms of personal knowledge, they have none.

So relators are going to get up and say, we have pled examples. Appendix B to the complaint has examples that purport to pertain to five -- five of the 317 defendants. There are major, major problems with the -- every single one of the examples. I don't have enough time, and I'm not going to go through them all, but if the Court cares to take a look at the supplemental briefing in which each defendant explained the problems with each of the exemplars and look at most

tellingly, at the plaintiffs' response where they basically said -- basically acknowledged the problem saying, yeah, you're right, it doesn't really match our allegations, but it doesn't matter because we have conspiracy allegations.

That's really their response. Yeah, our examples don't really make sense and match what we're saying, but go look at our conspiracy allegations.

I'll just give you two. The SC -- SZ, capital S, capital Z, example involves Geico, ECF Number 20, page 488, the top of the page says Berkshire Hathaway example.

Remember, the allegation of fraud in this case is that claims were not reported to Medicare. Before this litigation was filed, Geico showed the relators that SZ was, in fact, reported. Relators' opposition, ECF 37, page 3369, acknowledges that's true. It acknowledges -- it says, SZ's claim was reported to Medicare.

How could this possibly be an example of a claim not being reported to get -- to Medicare? This is an example. The relators will just say, oh, don't worry about that, they're conspiracy allegations. The examples are just thrown up there. They have nothing to do with the alleged fraud.

One more example, my client, Travelers. There's a person named J.B., capital J, capital B, ECF 20, page 502. J.B. slipped and fell in front of a restaurant in the Bronx, New York. J.B. sued the restaurant and the allegedly

responsible people. And Travelers is the insurer of the restaurant. They're fighting that out as of yesterday, in the Bronx County, who's responsible for that liability.

How is it possible -- it is not possible, that Travelers or Travelers' policy holder owes money to J.B.? Yet, the relators came in and said J.B. is owed money by Travelers. It makes absolutely no sense.

And again, you look at their opposition, and they're like, yeah, don't worry about it, just look at our conspiracy claims.

I get -- there's story after story just like this. The exemplars do not provide examples of the fraud that is frankly taken from Hayes and Takemoto and supposed, or posited in the complaint.

I bet a nickel that relators are going to get up here and talk about the Eleventh Circuit decision in Metropolitan Causality which was, again, submitted as supplemental authority to Your Honor very recently. In that case, an affiliate of one of the relators here asserted claims under the Medicare Secondary Payers Act against an insurance company that's not a party to this case.

The plaintiff in the Metropolitan Causality case alleged a private health insurer suffered an Article Three injury under the Act, because the liability insured owed it money.

The Eleventh Circuit said violations of the Medicare Secondary Payer Act, that one insurer owed money to another insure were sufficiently pled under Rule 8. That is not the case. This case is subject to Rule 9(b). The elements of a Medicare Secondary Payer Act violation are not the elements of a False Claims Act violation.

Remember how I started? The False Claims Act is not a general overarching regulatory statute designed to catch every foot fault and every breach of contract involving anything that touches the Federal Government. It is a fraud statute requiring all the traditional elements of fraud, and not anything less.

And this brings me to, well, I guess I'm running out of time, my last point, and I want to be clear about this. In the Metropolitan Causality case, the relators were saying, I represent an insurance company and this other insurance company owes me, an insurance company, more money. A classic insurer versus insurer dispute that happens every day of the week. There is no well-pled allegation, or even theory in this case, of an actual False Claims Act violation because there is no obligation to the Government at issue in this case.

30 -- Section 3729(a)(1)(G) of the False Claims Act is the statutory section under which relators are bringing Count One of their complaint. It is sometimes in the case law

known as a reverse false claim. To prove liability, you need to show that the defendant fraudulently failed to pay the money -- pay money to the Government or reduced an actual obligation to the Government.

Relators are complaining about defendants alleged failures to pay private health insurers, not the Government. Relators are complaining about the defendant's alleged failures to pay private health insurers, not the Government.

In fact, these guys go around the country filing hundreds of lawsuits that are the subject of our request for judicial notice, asking these same defendants to pay the private health insurers under the same exact theory, making the same exact allegations, using the same exact words. This case has nothing to do with an obligation to the Government.

If the alleged obligation is to a private entity, then it is not an obligation to the Government and there is no reverse false claim under Section (a)(1)(G).

No matter what you think of the rest of their complaint, this claim -- complaint must be dismissed pursuant to Rule 12, because there is no obligation to the Government pled. U.S. ex rel. Petras, P-e-t-r-a-s, 857 F.3rd. It's a Third Circuit case from 2017. And I cite it because it goes through a very long and careful analysis of the obligation to the Government requirement.

So the relators know they have a big problem here

with a lack of an obligation to the Government. So in my view, they've tried to get a little creative. So let me just deal with some of their answers.

First, relators have speculated that in the next contracting cycle, a private health insurer will bid more to take care of Medicare beneficiaries, and the Government will accept that bid and somehow us not -- our client's not reporting Medicare liability today will affect that future unaccepted contract bid that hasn't yet happened.

Even if that daisy chain of speculation about what might happen in the future comes to pass, there is still no existing obligation that has been avoided today. And that's what the statute requires.

Relators are just speculating about some hypothetical harm in the future, which kind of harm is not addressed by the False Claims Act. They have to show an existing obligation to write a check today, that was impacted or reduced as a result of the conduct they're complaining about.

The other thing they suggest for the first time in their opposition brief is that the Government has discretion to impose a $1,000 fine for each instance of not reporting. So that is why they say the defendant insurers don't report. I've been trying to wrap my head around that argument for two days, and I don't understand.

If the Government has a $1,000 fine for not

reporting, why would defendants not report? It just doesn't make sense. But putting that aside, there is actually a fine for not reporting, and we explain the actual current statutory and regulatory scheme in our reply brief at ECF 390, page ID, 4684. So they're simply wrong.

But let's just say they're right for a second. And there was a fine that the Government had the option to impose as its discretion, I'll refer the Court to footnote four of the Sixth Circuit's decision in Maur, M-a-u-r, which explains why a contingent fine isn't an obligation within the meaning of the False Claims Act.

In the words of the Fifth Circuit in the Simoneaux case, S-i-m-o-n-e-a-u-x, 843 F.3d 1033, it is, quote, "Widely accepted holding that contingent penalties are not obligations." End quote.

So lastly, to put a sheen of sort of law on their theories, the plaintiffs argue that they have something called an indirect reverse false claim, whatever that is, and rely on a case called U.S. versus Caremark, a Fifth Circuit case from 2011.

The statute, of course, says nothing about indirect reverse false claims. And Caremark, in the indirect false claim theory does not appear to ever have been applied anywhere in the Sixth Circuit. But taken on its face, it wouldn't apply in this circumstance.

In Caremark, a pharmacy benefit manager defrauded the State Medicaid agencies, one government, knowing that the state's obligation to the Feds, another government, would be impaired. It has nothing to do with this case. I haven't been able to figure out the analogy. And just sticking a label of indirect false claims on it doesn't make it -- doesn't make it so.

I'm going to -- I'm going to refer the Court, frankly to our discussion of our exemplars. There's no obligation at all in this case, and the plaintiffs have not come up with one, let alone one pled with particularity that's been avoided.

I need to just deal, before I sit down, with two things. With the conspiracy claim first, I mentioned U.S. v. Walmart in my discussion of public disclosure bar, which says that conspiracy is derivative of the primary claim. There can't be liability for conspiracy when there's no underlying violation.

The District Court in U.S. ex rel. Holbrook, H-o-l-b-r-o-o-k, 336 F.3rd at 873 from the Southern District of Ohio said that crystal clear. And that's why I cite that case.

Conspiracy claims can't rescue deficient primary claims. The failure to plead a primary violation of the Act dooms the entire complaint. But even on its own, the

conspiracy claim fail.

There is no agreement to violate the Act or an overt act in furtherance of an unlawful agreement pled anywhere in the complaint, nowhere, let alone one with particularity. The who, what, when, where, why of this alleged agreement among 317 defendants, I couldn't find it anywhere in the complaint. So I took a look at the section of their brief, the relators' brief in which they purport to justify their conspiracy claim, which is pages 45 to 47 of ECF 376, page ID 3940. There is literally nothing there. Not a peep about the particular circumstances of an agreement, not a peep about understanding, or anything that could support a conspiracy claim.

Plaintiffs want the Court to infer a conspiracy, but Iqbal Twombly and Rule 9(b) require such an inference to be based on plause -- to be plausible and actually based on the facts alleged. There is no fact -- I understand the rhetoric, but there is no fact alleged from which the Court can make a plausible inference that 317, or even two defendants conspired to violate the Act. There's no plausible reason to even offer why defendants would enter into such a conspiracy, not even -- or facts showing that they did.

And as for the overt act in furtherance of this nonexistent agreement, there's one thing cited. The complaint cites the revision of a non-party's contract with Defendant ISO. There's no allegation that ISO breached the contract.

There is no allegation that defendants were involved in that. There's no fact pled anywhere, that has anything to do with anybody other than the usual business arrangement. There simply isn't an overt act.

And lastly, if it's not obvious, Your Honor, Count Three of the complaint deals with state law claims. And I think the easiest way to address them is just not to deal with them, and decline to exercise supplemental jurisdiction once Your Honor chooses to dismiss Counts One and Two.

If Your Honor decides to get into them, you'll find that the causes of actions purportedly asserted under most of the state claims don't even exist. And relators, in most instances, don't have the right to bring them. They have to be brought by a local law enforcement official, if at all.

So with that, I will sit down. And thank Your Honor for your indulgence in allowing me to speak to these issues. I hope I won't have to, but I'd like to reserve just a few minutes to respond to anything my colleagues say.

Thank you.

THE COURT: Okay. Thank you.

Okay. Who is -- are you going to respond now? Who's responding first?

MR. ARMAS: Judge, I am. Judge, may I have a personal break, please?

THE COURT: Sure. How long do you need?

MR. ARMAS: Five minutes.

THE COURT: Okay. Let's take a five-minute break.

MR. ARMAS: Thank you, Judge.

CASE MANAGER: All rise.

We're in recess. You may be seated. We will start in five minutes.

(Recess taken from 2:58 p.m. to 3:04 p.m.)

CASE MANAGER: All rise.

Court is now back in session. You may be seated.

THE COURT: Okay. I'm ready to begin again.

MR. FRIEDMAN: Good afternoon, Judge. And, thank you.

THE COURT: You're welcome.

MR. ARMAS: Again, I am Alfredo Armas, and I represent the co-relators. Judge, a lot of this argument has been done in a -- in a vacuum. And I think it's important that we get the full context of what it is that we are addressing in this case.

Medicare existed and was acting, not as a health insurance company, but as a payer as a matter of policy. And that led relatively quickly to the bankruptcy of the Medicare Trust Fund.

Jimmy Carter appointed a gentleman named Joe Califano as director of HEW. It was Health Education and Welfare at that time. And Mr. Califano was disconcerted that all other

health insurance companies in the United States were able to coordinate benefits and were able to subrogate, and were able to seek monies from other insurance companies, for example, that insured premises where a slip and fall occurred, insured automobiles, and provided no-fault insurance.

Mr. Califano created what was then known as HCFA in the Carter Administration, and what we know today as CMS or the Centers for Medicare and Medicare Services. And Mr. Califano attempted to subrogate Medicare claims, and seek reimbursement from insurance companies. At that time, presidents acted through Congress, and not so much through excessive order.

And finally, in 1980, the following year, Congress passed the Medicare Secondary Payer Act. And what the Medicare Secondary Payer Act says beyond doubt or impaired venture, is that Medicare will be the payer of last resort. And before Medicare has to expend one penny on the healthcare of its enrollees, the insurance company that are reliable for the injury or that have caused the need for medical care have to step up and pay for those services. There's no dispute on that.

And we are dealing with insurance companies that provide automobile coverage, that provide no-fault, that provide slip-and-fall coverage, et cetera. So that should have been the solution to this problem of Medicare losing

billions of dollars and putting the Medicare Trust Fund in peril. And, of course, insurance companies being insurance companies, that's not what happened at all.

And what Congress discovered after the implementation of the Medicare Secondary Payer Act, is that the insurance companies weren't paying. Not only were they not paying, they were concealing their liability. When they were obligated to pay, they wouldn't come forward. And there was really no mechanism for CMS or HCFA to determine when it could seek reimbursement.

And the reason there's reimbursement, there's a little twist to the Medicare Secondary -- Secondary Payer Act. And that is, the Government doesn't want to impact healthcare providers. So healthcare providers shouldn't have to wait for the dust to clear, and for a determination to be made as to who is the primary payer. So most of the time, the Government will go ahead and pay primary care physicians, will go ahead and pay hospitals under Medicare parts A and B, and then expect to get reimbursed.

So it's either the primary care -- the primary payers have to pay initially, or the primary payers have to reimburse CMS. None of that was happening. None of it.

So Congress came up with Section 111 requirements. And we have a timeline here, Judge. And it shows that this ravine has --

THE COURT: Counsel, excuse me, do you have a small -- a paper copy of that?

MR. ARMAS: Yes, we do.

THE COURT: Yeah, that would be good. That would be nice. Thank you.

That's pretty small, too, huh?

MR. ARMAS: Yes. Yes, Judge, I --

THE COURT: No, it's not. I can see.

MR. ARMAS: I complained to my young colleagues.

THE COURT: It needs to be big.

Okay. All right. Go ahead, though.

MR. ARMAS: It does.

Judge, in order to remedy this ongoing problem, Congress enacted the --

THE COURT: Now, wait a minute, which ongoing problem? The problem, the subject of the case, or the chart?

MR. ARMAS: The problem with Medicare not getting reimbursed.

THE COURT: Okay. That was intended to be a lighthearted remark.

Okay. Go ahead.

Tell me about what you were pointing out on the timeline.

MR. ARMAS: Judge, it's the very first slide.

THE COURT: Okay.

MR. ARMAS: And it says December 29, 2007.

THE COURT: Okay.

MR. ARMAS: And that's when the Section 111 reporting requirements came into effect. And the Section 111 reporting requirements are very simple. It says, listen, insurance company, when you are primarily liable because it is a no-fault situation, or because you have insured a motorist that has injured a third party, and you are liable for healthcare, you need to step forward and you need to notify CMS or then HCFA, now CMS, that that is the case.

So for us, the problem is solved. Now, we have the Medicare Secondary Payer Act. Before, the Government had no way of knowing when the primaries were liable. So now, there is the Section 111 reporting requirement. And Judge, nothing happened. Absolutely nothing happened. Why? Because the insurance companies are incorrigible, and they weren't reporting under Section 111.

They simply weren't advising CMS. And how do we know that? Let me tell you what MSP is, because a lot has been done in the moving papers to denigrate MSP. And Judge, I will tell you, MSP has taken on these insurance companies. And yes, it was a nascent model at one point. Mistakes were made. It has been perfected. And I believe that MSP has had a clear run of exceptional success in the -- in the United States Circuit Courts of Appeal, and we cited those cases to the --

to the Court.

Judge, one in particular, because it -- it really addresses arguments that were presented here today. Judge John Walker is a sitting judge in the Second Circuit United States Court of Appeals, and he was on loan to the Eleventh Circuit when ACE was decided. And this is what he said. And it is precisely what MSP is addressing.

The primaries are not paying primary, they're waiting. And they -- and the secondaries pay and make the payment, and then the primaries are not stepping up after those payments are made to reimburse. They are waiting. And they're, obviously, from an economics' perspective, to their advantage to do that, to put it off as long as possible and have the lawsuits come in as limited a way as possible. And that's why your client -- what your client is doing is problematic from their perspective because it aggregates these claims and goes after them after the primary reimbursements and must, if you will.

And then it goes on to say, if the primaries come in and pay, then the taxpayers are relieved of this risk to the extent of the primaries' obligation.

Judge, I will tell you that in ACE, the Eleventh Circuit Court of appeals requested that Health and Human Services, the successor to HEW, weigh in on these cases. And Health and Human Services came in and filed a brief. And this

is what they said.

The purpose of those provisions is to protect the fiscal integrity of the Medicare program by ensuring that Medicare will not be required to pay for items or services for which a primary plan should be responsible. While payments do not go to the Medicare directly, in Medicare advantage cases, payment by primary payers reduces costs, and some of those savings are passed on to Medicare through reduced costs, or to the beneficiaries through expanded services.

Why have I said that? It has been argued from the lectern that we are not presenting -- that these relators are not presenting a quorum to the United States Government. In fact -- and point of fact, Judge, we are.

First, we are alleging an indirect false claim. And what does that mean? An indirect false claim is nothing more than your typical fraudulent tax return. You have an obligation to the United States Government. You utter a paper that conceals or lowers that -- that liability, that is a reverse false claim. And that's what they do every time they fail to report their Section 111 obligations, primary payer obligations.

But in addition, Judge, and I want the Court to be very clear on this, there are different kinds of Medicare. There is Medicare's parts A and B, and that is where the Government directly pays for an enrollee's healthcare. And

then, there is Medicare part C. And part C is a traditional HMO type of program where a health insurer will be obligated to provide all of the medical care that is otherwise provided by the Government in exchange for a capitated per member, per month payment from the United States Government.

So in this case, we are alleging both. We are alleging, number one, these insurance companies are defrauding the United States Government, but -- by not reporting their Section 111 primary payer obligations through ISO. They all use ISO as a depository of their data, and that data doesn't get transmitted to the United States Government as Section 111 reporting as it should.

And number two, because they don't reimburse the Medicare part C as well, they are also impacting the Medicare Trust Fund. And that's what Health and Human Services said when they said, while payments do not go to Medicare directly in Medicare advantage cases, payment by primary payers reduces costs, and some of those savings are passed on to Medicare through reduced costs or to the beneficiaries through expanded services.

What that means, Judge, is that when these insurance companies, HMOs, think of United Health and Humana, when they negotiate with the Government, they negotiate based on the prior years' experiences. So if the prior years' expenses were higher, and the reimbursement to these insurers -- to

these healthcare plans was less because the primary payers weren't paying, then the Government is impacted, of course, because the contracts will be higher. So we have both of those claims.

Judge, the Court in ACE went further. And in agreeing with MSP on all issues, the ACE court went on to define when primary payers like these defendants have constrictive knowledge that they owe reimbursements. And that is the filings with Health and Human Services and, of course, when it is a no-fault coverage PIP, they are on notice immediately that they have to provide the -- the cost of the medical services.

Judge, I would ask the Court to please review MSP A claims versus Tenant. It is cited at 918 F.3d 1312. It's a 2019 case in the Eleventh Circuit.

THE COURT: Give the citation again.

MR. ARMAS: Yes. 918 F.3d, 1312.

THE COURT: Thank you.

MR. ARMAS: Eleventh Circuit.

There is MSP v ACE, where Judge Walker sat on the Eleventh Circuit that I just cited to, and that's at 974 F.3rd 1305; MSP versus Kingsway, and that is at 950 F.3d 764.

Judge, in short, far from -- from being a meddler, MSP Recovery has, in fact, demonstrated its ability to bring these insurance companies to task.

Let me explain what MSP does. And Your Honor will see why MSP is not only the original source of this information to the Government, but it is the only possible source of -- of this massive fraud that is being perpetrated on the United States Government.

MSP has a database of approximately 40 million lives. And this is what happens. When a health plan like Humana or United Health has an enrollee that is injured, and the injury is the result of trauma as opposed to chronic illness or -- or disease, then that plan creates what is called an encounter. And they will treat the -- the enrollee as a patient, provide primary care or hospital care, as the case may be. And they will determine from the enrollee that the injury was a result of a car accident or as a result of a dog bite or as a result of a slip and fall and an encounter is created.

When MSP obtains that data from these healthcare providers and healthcare plans, it then bumps up the data against accident reports, against ambulance services. And in those accident reports, the peace officer that -- that wrote up the report will invariably say who insured whom in the -- in the accident.

So now, MSP, as it bumps up this data using its proprietary software, has determined that there was healthcare provided by a Medicare plan to a Medicare enrollee. And now that that -- those medical services were provided as a result

of trauma, either an accident or a dog bite, a battery, and that there is primary insurance coverage.

So now that we have that data, MSP then goes to another service, which has all of the data of reports. It doesn't have the actual reports. Only ISO has that, and the -- and the insurance primary care -- primary plans themselves. But this system called Ability has all of that data of all of the reporting.

So what MSP has done in this case, is gotten the data from these health plans and health care providers, that services and goods have been expended by these plans to provide medical care to a Medicare enrollee who was injured as a result of an accident, where one of these insurance defense companies was a primary payer. And then, they have taken that data and bumped it up with the Section 111 reports.

And of course, if the law is being followed and Congress' mandates were to be effective, we wouldn't expect that in virtually all of the cases where that scenario occurred, where Medicare enrollee has been injured as a result of the negligence or the -- the PIP coverage covered by one of these insurance defendants, then we would expect a Section 111 report to be identified by -- by the Ability data.

And in fact, what happens, Judge -- what happened is that we took to the Government before filing. And this is actually attached to the body of the complaint --

THE COURT: Okay.

MR. ARMAS: -- itself.

And what we discovered, for example, State Farm, we looked at approximately 32,000 examples. And this is not the entire universe.

Remember, we have data of approximately 40 million lives. But we bumped up 32,000; 33,000 discrete cases where Medicare services were rendered to a Medicare enrollee and paid for by a Medicare plan, where State Farm was the primary payer. And what happened is that we discovered that seventy -- 7,500 of those 33,000 events were reported to CMS using Section 111 reports, and a whopping 27,000 cases were not reported.

And the same thing happened with the Berkshire Hathaway Group, the Progressive Group, Nationwide, Liberty Mutual, Travelers, and all -- and so on down the list, every single time that we bumped up this data, we returned algorithmic evidence that these insurance defendants were not reporting to -- their Section 111 requirements to the United States Government.

If they do not report -- because this is the only way that we can get reimbursement or payment. And by we, I mean the Medicare plans and Medicare itself. This is for Medicare. The only way that a recovery is affected is through the Section 111 reporting.

So we know, or certainly it is not an improper -- an improbable leap of logic to assume that those monies have not been recovered. It's -- it's the same, Judge, as if I had income and I didn't report it to the IRS. And that is a reverse false claim under the statute. And that is what MSP brings to bear.

Judge, I want to address these two supposed public disclosures. One is Takemoto, the other one is Hayes. And this is -- this is what the motion to dismiss alleges Hayes said. And this is at page 51 in the motion to dismiss, Judge.

And these defendants say with respect to Section 111 reporting. Remember, Judge, the gravamen of our complaint is that these insurance defense -- defendants are not reporting their primary obligations pursuant to Section 111. That is what we are alleging.

This is what they say Hayes alleged. With respect to Section 111 reporting, Hayes alleged that the insurers were -- and they quote, "Required to determine whether a claimant was entitled to Medicare benefits, and provide the claimant's identity and other information needed to ultimately ensure reimbursement, but failed to do so." And they said -- and they cite the Hayes complaint at paragraph 375 and 376.

So they are telling this Court that Mr. Hayes alleged Section 111 reporting was -- was ignored by these insurance companies.

Let me tell you what Mr. Hayes actually says in his complaint that they are proffering up as having the same, or substantially the same allegations. This is Mr. Hayes speaking for himself.

This supplement to the Ship Act, and incidentally, Judge, this is Section 111, the supplement to the Ship Act, though delayed in its enactment, has apparently raised the consciousness of liability insurers generally, such that there appears to be more compliance with Medicare reimbursement than during the time periods cited herein when there was essentially complete avoidance.

So Mr. Hayes is saying, listen, I am making allegations of noncompliance by primary payers, but it appears from my temporal point of view today, that the insurance companies are bringing -- are getting their act together. He goes on. Despite however, the appearances of increased compliance, all the defendant insurers are expanding their indemnification phraseology and general releases.

And I'll get to that in a second.

The defendants still seek to protect their interest, avoiding their obligation of ensuring repayment by co-opting and intimidating claimants and their attorneys with ever broadening indemnifications qualities.

And here's the key. At paragraph 379, this is what Mr. Hayes says. The above cited section, relative to the

failure to report, is entirely distinct and totally independent of the MSP sections and responsibilities to reimburse and repay under which this suit is brought.

Mr. Hayes, himself, is saying, yes, now -- and at that time, at that point in time, Section 111 still had not been implemented. Implementation doesn't occur until 2011 and 2012 depending on whether it's -- it's PIP coverage or a third-party liability. When Mr. Hayes is making these allegations and his very last release, that's what he was complaining in his very last release, that's what he was complaining about, is 2010. But he is almost speaking to the insurance defendants and saying, no, no, no, that's not what my case is at all. And he says, the above cited section relative to the failure to report -- there's no question that he's referencing Section 111 -- is entirely distinct and totally independent of the MSP sections and responsibilities to reimburse and repay under which this suit is brought.

He's saying it has nothing to do with my suit. Section 111 has nothing to do with my suit. And, of course, Section 111 is exactly what our lawsuit is.

Similarly, Takemoto, Judge. And this is another case that is proffered as a public disclosure bar because the -- the claims were substantially the same.

And what happened with Mr. Takemoto is that Mr. Takemoto was soliciting the insurance industry for him to

act as an outsource compliance officer, and he had these seminars. And in these seminars, he would pitch himself and his company as an outsource compliance officer to ensure compliance with CMS. At that time of which he speaks, Section 111 had not been implemented. And this is what he says.

Takemoto alleged that he approached Allstate to pitch reporting to Medicare as required by the impending MMSEA 111 legislation. And that's at paragraph 93 of Mr. Takemoto's complaint.

So Mr. Takemoto is talking about a regulation that is going to come into effect in the future. He cannot possibly be claiming that the insurance industry is not compliant with Section 111. One, because it still hasn't been implemented; and two, because he cannot be predictive if he is going to bring a claim.

Which brings me back to another allegation that -- another argument that was made, that we don't have standing because these allegations are really allegations that belong to private parties.

And Judge, I will direct you to Judge Murphy because he really dove into this issue of standing. And he states in his memorandum order, what is more, the relators establish three standing elements. Relator MSP WB allegedly has direct knowledge of tens of thousands of instances wherein the defendant failed to report their primary payer responsibility,

causing government health programs to reimburse for the beneficiary's accident -- accident-related medical expenses.

And he cites ECF 41.

And the relators claim that the defendants systematically failed to completely or adequately satisfy Section 111's reporting requirements. That's exactly correct.

Taken as true, relators established a fraud inquiry on the United States due to Defendant's failure to satisfy Section 111's reporting requirement. One relator even has direct knowledge of the defendant's reporting failures, and can trace defendants to the alleged fraud. And a favorable decision would likely redress the alleged fraud injury. Because the relators have standing, the Court will deny the defendant's motion in regard to standing.

Judge, I am -- I am reading from Judge Murphy because it, in a very concise manner, sets out exactly what these relators are alleging. And it's not an injury to private parties. It is a massive fraud that is being perpetrated upon the United States.

Judge, I want to address a little bit of the public disclosure bar.

A lot of authority is cited by the defendants that completely ignores the amendments that have been made. And I will tell Your Honor that one of the most important of these amendments is contained in the Affordable Care Act.

And this is what the new public disclosure bar says. First of all, it has taken out a -- a jurisdictional issue, which is very important for this case, Judge, because previously, if a public disclosure barred the action, then the Court was without jurisdiction. The Court had to dismiss the action, and the judicial labor was ended. That is no longer the case.

Every circuit that addresses has said the Affordable Care Act has amended the statute, so that now this is either a motion to dismiss with leave to amend, or it is subject to -- it is an affirmative defense, which should be pleaded.

Judge, I would ask at this time, and let the Court know that this is the first time, this is a first amended complaint, and this is the first motion to dismiss that addresses it. If Your Honor finds any deficiencies, and I don't believe that there are any -- and Judge, please, we -- I implore the Court to ignore the allegations as to what MSP has -- has done and failed to do, and looking at the exemplars, and really concentrate on this lack of reporting. Because ultimately, that is the obligation that the insurance defendants have, and that is the obligation that they are assuring.

Beyond it being no longer a jurisdictional hurdle, the statute has been amended, and now reads as follows:

The Court shall dismiss an action or claim under this

section unless opposed by the Government, if substantially the same allegations or transactions were publicly disclosed in a federal, criminal, or administrative hearing in which the Government or its agent is a party.

And Judge, what they're alleging -- what they are alleging is, (A), that even though the United States Government declined intervention in Hayes and Takemoto, that Hayes and Takemoto are agents of the Federal Government, and that Hayes and Takemoto, which have nothing whatever to do with Section 111 reporting, somehow contain substantially the same allegations or transactions as alleged in the action.

There is now, a safety net for relators, which wasn't there before. And that safety net is the original source provision of the new Affordable Care Act, False Claims Act. And it says, here's an exception. The exception is, if you are an original source of the information who has knowledge that is independent of, and materially adds to the publicly disclosed allegations or transactions.

So it is an original source who has knowledge that is independent of, and materially adds to the publicly disclosed allegations.

Now, the Sixth Circuit has said, these are significant changes. This is not nothing.

The Court in Holloway, and that's cited at 960 F.3rd 836, the Sixth Circuit United States Court of Appeals states,

from a textural standpoint, substantially the same, facially demands a greater degree of similarity between the qui tam complaint and the prior disclosures than based upon. Based upon was the prior standard.

And substantially the same, undoubtedly, is more rigorous than even partly based upon, as we have interpreted based upon to mean.

Court said, having held that Holloway's claims do not survive pre-amendment public disclosure, we must decide whether they surmount the more lenient post-amendment public disclosure bar.

At the same time, we continue to be guided by the statute's general purpose of encouraging genuine whistleblower actions while snuffing out parasitic suits.

Judge, again, I implore Your Honor to look at Holloway. And in Holloway, something very interesting happens. In Holloway, the Court, after defining and saying this change is significant, it's not nothing, goes on and says, you know, this sounds like it's an original source argument, but unfortunately, the -- the defendant has not -- the relator has not made that argument. Had the relator made that argument, we may very well have considered it.

We are making that argument, Judge, that we are an original source. And what an original source means in this case, is that we have brought to bear, years of litigation,

discovery, deposition testimony, some of which is appended. And with that deposition testimony in the other cases where we have taken depositions, shows -- is that there's a reason. There's a reason why we have this extraordinary gap between reported and unreported. And that is, because these insurance defendants willfully refused to obtain the information that would disclose whether their insurers or those who their insurers have injured are Medicare beneficiaries.

Judge, there is an appendix. Read those deposition excerpts. They don't ask social security numbers. They don't ask for -- for any identifiers that would be -- that would show them to be Medicare beneficiaries. They purposely put blinders on. They purposely put blinders on, don't obtain the information. They don't report. They don't data to ISO. ISO, as part of this massive fraud upon the Government does not submit Section 111 reports properly.

And then, after we provide all of the data that we've provided, using our own data for this, they come into court and say, in effect, you know what, Judge, because we have so successfully concealed our primary payer status, they don't have the data to prove it. And the Sixth Circuit makes short shrift of that sort of argument.

There is a case, it is called Prather. And there is another one called Duke Energy. And, Judge, Duke Energy is cited at 681 F.3d 803.

I'm sorry, that's not the -- the citation. It is cited at 681 F.3d 788. And this is what the Court said.

With respect to Defendant's 9(b) argument, this Court has held that it is a principle of basic fairness that a plaintiff should have an opportunity to flesh out her claim through evidence unturned in discovery.

Rule 9(b) does not require a missing omniscience, rather the rule requires that the circumstances of the fraud be pled with enough specificity to put defendants on notice as to the nature of the claim, especially in a case in which there has been no discovery. Courts have been reluctant to dismiss the action where the facts underlying the claims are within the defendant's control.

What happens here is that the facts are exclusively under the defendant's control, except for such facts as we have determined in other litigation where private parties are plaintiffs, and other than where we would have been able to bump up against ability, which is the massive information of all liability, and using our accident reports, ambulance reports, et cetera.

There is a -- a case that is remarkably similar. It is not from the Sixth Circuit. But unlike the Court in Holloway that never had an opportunity to look at the original source doctrine, the Third Circuit in Majestic Blue Fisheries did. And Judge, I implore the Court to look at Majestic Blue

Fisheries more than anything because it is so similar to our case.

In that case, you also had a relator that was an attorney. And you also have a situation where the attorney obtained original source information through discovery in prior litigation. And the Court, unlike the Court in Holloway, where it was foreclosed from determining whether the relator was an original source or not because it wasn't argued, this relator did argue it. And the Third Circuit found that they were original sources.

And one of the things that is argued by the defendants, is that MSP WB doesn't have this knowledge. All of this knowledge was obtained by MSPR and related entities and affiliates. And that is true. But under the new public disclosure bar in the Affordable Care Act, that is absolutely of no moment. And that is because the original source was, bring information that is new, not to the entire universe, but new in comparison to what has been proffered as the public disclosure bars. In this case, Takemoto and Hayes.

So that all MSP WB has to say is, as far as Takemoto and Hayes, those complaints, this is new. These are new allegations that we bring. Whether or not I have obtained them and I am the repository of the knowledge from my affiliates, the MSP entities is absolutely of no moment.

And this is the Court in Majestic Blue Water. What

happened in Majestic Blue Water is that there is a treaty where the United States have determined that our fisheries are being poached by every nation in the world. And this is especially true in the South Pacific. So we have enacted laws that say, only United States' vessels, fishing vessels manned or operated by Americans can fish these waters. And what the -- a group of Koreans was doing, is they were getting straw purchasers, vessels, being Americans, and they were getting a straw captain, an American, to be a captain on the boats when in reality, the Koreans were in charge of the vessel and the vessel was really owned by Korean companies.

And what happened is that one of the crew members died on one of these voyages. And the relator, being an attorney, brought a lawsuit, a wrongful death action. And in the wrongful death action, he found out everything that I am telling the Court. And he took depositions where he was able to elicit testimony that, in fact, the Koreans were acting through straw purchasers and straw crews. And then, he brought a qui tam action against the owner of the vessel, Majestic Blue.

And in the action, the defendant said, no, no, your action is barred. There's a public disclosure that predates your lawsuit. And that public disclosure is all over the news. And the Third Circuit looked at it and said, gee, yeah, it is all over the news. You are correct, Defendant.

But you know what? This relator, this attorney that has obtained this information independently of those news articles is an original source under the new Affordable Care Act version of the public disclosure bar. And the Court said the following.

But the PPACA's new definition of original source requires an entirely different analysis. An original source is now defined as one who has knowledge that is independent of, and materially adds to, the publicly disclosed allegations or transactions. And that is bolded. In our case, Takemoto and Hayes.

This definition, therefore, states that a relator's knowledge must be independent of, and materially add to, not all of the information readily available in the public domain, but rather only information revealed through a public disclosure source in Section 3730.

And I cite that, and I emphasize it because the defendant's argument is, because this information is really in the hands of the MSP affiliates and not this relator, you are not an original source. And the Third Circuit really dives into it and really parses the land and says, no, no. The information must only be independent of Hayes and Takemoto, not also independent of its own affiliates' knowledge.

So, they fail there.

They -- the defendants make light of our reference to

Walburn versus Lockheed Martin. And indeed, in Walburn versus Lockheed, the Court -- and it is a Sixth Circuit case cited at 431 F.3d 966.

431 F.3d 966 was looking at the first-to-file bar in the -- the Affordable Care Act's version of the public disclosure bar. There is a -- I'm sorry, of the False Claims Act.

There is a first to file provision in the -- in the False Claims Act as well. It is not the multi-district first to file provision that we're familiar with.

And the Court, in addressing why a prior case was not a first to file, said it's not because it doesn't -- that case, that complaint didn't meet the 9(b) pleading requirements. And the Court says, a complaint that is insufficient under Rule 9(b) is dismissed precisely because it fails to provide adequate notice to the defendant of the fraud it alleges.

A complaint that fails to provide adequate notice to a defendant can hardly be said to have given the Government notice of the essential facts of a fraudulent scheme, and therefore, would not enable the Government to uncover related frauds. So the Court determined it's not a first to file.

Why do we rely on that case? Why do we cite it? We cite it because in order for there to be a public disclosure bar, the prior public disclosure must put the Government on

notice of the fraud.

So that Takemoto and Hayes must put the United States Government on notice that the insurance defendants are going to be scuffles once Section 111 is implemented, and they are not going to comply with the Section 111 requirements. Something that it absolutely does not do.

But in addition to that, Hayes and Takemoto were both dismissed for failure to allege fraud with specificity. And it was more than that, Judge. Mr. Hayes, who was a lawyer, was actually admonished by the Court, and Rule 11 sanctions were imposed upon him for bringing an action that had absolutely no support on a first-hand basis.

So Hayes -- remember, Hayes is the gentleman that says my case, this case has nothing to do with Section 111 reporting, he says it himself, also failed to allege 9(b) -- meet 9(b) standards, and his action was dismissed and sanctions were imposed upon him.

The same thing happens to Takemoto. The same thing happens to Takemoto. Takemoto's case was dismissed for a failure to stay -- to meet the 9(b) standards.

And the Sixth Circuit in Walburn versus Lockheed says a complainant that fails to provide adequate notice to a defendant could hardly be said to have given the Government the essential facts of a fraudulent scheme, and therefore, would not enable the Government to uncover related fraud.

Judge, the insurance defendants also intend to make sure to make a short shrift of our allegations. Our allegations go into detail.

The reason we submitted Metropolitan from the Eleventh Circuit United States Court of Appeals to have supplemental authority is because that court was dealing with exactly this sort of evidence. Instead of individual exemplars, we were looking at statistical samples. And the court said, you know what, that is sufficient to allege a plausible claim.

These are the allegations that we have made. We allege a willful failure to correct inaccurate reporting, even after specific notice from relators.

Defendants have failed and refused to report and reimburse for a specific past conditional payment, even after data matching with MSP, the defendants still failed to report their primary payer status. And that's an allegation made at paragraphs 5 and 472.

One of the things that happened here, and I explained to Your Honor how the Ability reports and that massive data dump works. It merely tells us whether, in fact, a primary payer has reported liability allegations or not. That's all it tells us.

But before that, we had, as a client, as a paying customer of ISO, we had access to ISO's data to determine the

extent of noncompliance with the insurance industry.

And amazingly, Judge, under pressure from the insurance industry, ISO barred us, particularly, to the data even though we were paying customers like everybody else. And then, they amended their rules of engagement. So that in order to become a customer of ISO, you have to admit that you are not a collection agency, that you are not looking for fraud, that you are not an attorney bringing class actions, that you are not sifting through the data to determine compliance or noncompliance with the Medicare Secondary Payer Act. And, we were debarred.

So that again, there is this massive wall that prevents MSP, the relator, and it prevents the United States Government from looking at the raw data. And the only access that anybody has is what ISO desires, or ISO wants the world to see under its Section 111 reports.

We also alleged purposeful changing of ISO terms to use -- to prevent MSPA recovery efforts. And that allegation that I just explained is made at paragraphs 496 through 497.

Willful failure to report. And we have ten exemplars. We also make the allegations at paragraphs 527 through 537. We have appendices. And Judge, we have given the Court the raw data.

Incidentally, Judge, all this information was provided by Mr. Akeel to the United States Government before

the filing of the action. I don't believe there's any dispute as to that.

Willful failure to report and reimburse. Failure to report or report properly. In tens of thousands of instances, defendants have failed and refused to report thousands of instances of primary payer status, as determined from the later MSP's independent data analysis of its non-proprietary claims data.

Allegations are made at paragraphs 27, 34, 50, 84, 91, 139, 176, 203, 227, 258, 296, 307, and 351.

That's paragraphs 27, 34, 50, 84, 91, 139, 176, 203, 227, 258, 296, 307, and 351, and the chart, which is also incorporated into the first -- into the bottom of the first amended complaint.

And that they have left critical information out, what I alluded to earlier, Judge. When they take these critical applications, they don't ask, are you a Medicare beneficiary. They don't ask for social security numbers. They don't gather the information that would provide -- that would disclose that they are beneficiaries.

Now, they have a second opportunity when an accident actually occurs and an adjuster is sent out to adjust the claim. And there's a boatload of questions that these adjusters ask.

Was there an injury? Was there a laceration? Who

was at fault? What were the conditions? Were you wearing glasses? Was the driver wearing glasses? Was alcohol involved? Et cetera, et cetera. And none of these questions, none of them have anything to do with Medicare eligibility. They put blinders on purposely.

And Judge, the Sixth Circuit has basically said, we -- you cannot put blinders on, and then plead lack of specificity.

Conair versus J.C. Leasing, 921 F.2d 276. 921 F.2d 276. It's a Sixth Circuit case, 1990, by conveying all of its interest in the terminal facility, the defendant divested itself of the ability to perform its obligations under the covenant not to compete. This amounts to a breach of the purchase agreement by repudiation.

The FDIC's obligation to comply with the agreement necessarily encompasses the obligation not to voluntarily disable itself from complying with it. And that's City Bank versus FDIC 857976.

And what they do, and we have alleged, is that most of these insurance companies sloth off this responsibility to ISO so that they want to argue that, listen, we're not the ones that perform -- that -- that comply with our Section 111 reporting requirements. That's on ISO.

ISO is alleged, in this complaint, to be the very -- the very center of this conspiracy to defraud the United

States Government.

Judge, if I -- if I could have two seconds to consult with my --

THE COURT: Sure, you may.

MR. ARMAS: -- co-counsel.

THE COURT: Yes.

MR. ARMAS: Judge, we want to make the Court aware, there is a case Harper, H-a-r-p-e-r, versus Muskingum, and it's a Sixth Circuit case. And we are alluding to it, reciting to it, Judge, because the argument was advanced by a -- by the insurance defendants, that you cannot have a contingent claim, that the claim must be formed fully. And we're saying that's not our claim. Our claim is a failure to report is a reverse false claim.

And indeed, there are -- there is a possibility of unliquidated and contingent claims to come within the False Claims Act. And the cite is 842 F.3d 430, Sixth Circuit, 2016.

THE COURT: Give it again.

MR. ARMAS: 842 F.3d 430, Sixth Circuit, 2016.

And the spelling of Muskingum is. And the spelling of Muskingum is M-u-s-k-i-n-g-u-m, Watershed Conservancy.

THE COURT: Okay. Thank you.

MR. ARMAS: Thank you, Your Honor, for indulging us. We do appreciate it.

THE COURT: All right.

MR. ARMAS: And I appreciate your concern for our safety as well, Judge, on the masks.

Thank you.

THE COURT: Thank you.

MR. FRIEDMAN: Your Honor, in terms of scheduling and things to come, I would like -- sorry, for the record, it's Bryce Friedman for the defendants.

I would like just five minutes, or a short amount of time to respond to some of the things the relators said. On our side, I believe we only have one other attorney who wishes to speak for a short period of time, no more than five to ten minutes, on State Farm's specific issues.

So I'm happy -- I'm happy to reply briefly now, or otherwise operate at Your Honor's pleasure.

THE COURT: Okay. So tell me who's going to speak for State Farm.

Will that be Douglas Baruch?

MR. BARUCH: Yes, Your Honor.

THE COURT: Okay. So Ms. Newton and Mr. Folland are not going to argue?

MS. NEWTON: That's correct, Your Honor.

MR. FOLLAND: That's correct, Your Honor.

THE COURT: Okay. Okay.

And on the other side, I just have Mr. Akeel; is that

correct?

MR. AKEEL: That's correct, Your Honor.

THE COURT: Okay.

Now, Counsel, do you really want five minutes, or do you really want some other amount of time?

MR. ARMAS: No, I will be very brief.

THE COURT: That doesn't say you want five minutes.

MR. ARMAS: How about six?

THE COURT: Okay.

But now, don't repeat your prior argument because --

MR. FRIEDMAN: I definitely --

THE COURT: -- I have been listening, and I am taking notes.

MR. FRIEDMAN: I definitely will not do that.

THE COURT: Okay. Thank you.

MR. FRIEDMAN: If I may, I just want to respond to just a few particular points that were made by relators' counsel.

THE COURT: Okay.

MR. FRIEDMAN: First of all, he was very clear at the very end that this is not -- this is a reporting case, not a payment case.

THE COURT: Not a what?

MR. FRIEDMAN: Payment case.

THE COURT: Okay.

MR. FRIEDMAN: And money is the only thing that the False Claims Act deals with under (a)(1)(G). And there is no obligation that they have identified with any particularity that has been avoided.

Next, I want to call the Court's attention to 42 U.S.C., 1395(y)(B)(8). And the reason I'm calling your attention to that statutory provision is because that's the provision that outlines the reporting requirements, not what realtors' counsel articulated them as, but what's in that provision should the Court have any interest in that provision.

Next, I want to respond to the arguments that Takemoto and Hayes were not public disclosures.

I am looking at a section of the Takemoto complaint titled, ***Congress Changes MSP Rules in 2007***, and there are pages and pages of discussion of Section 111.

Then, I'm looking at Count Nine, which involved my client. I was actually there for Takemoto. I argued the case in the Second Circuit. And there were absolutely allegations of Section 111 reporting. That's in Count Nine beginning at paragraph 170.

I was heartened to hear, again, the distinction between reporting and payment that realtors' counsel thought so important. Paragraph 379 of the Hayes complaint was the one he focused on. There are two sentences in that paragraph.

One talks about Section 111 reporting, and two talks about repaying medical expenditures.

And relators say this complaint, the one that is here today, is only about Section 111 reporting. Well, if it's only been Section 111 reporting and not about medical expenditures, again, we have no obligation that is at issue in this case.

Now, there indisputably has been a public disclosure. I think the 20 pages or so analysis in just -- Judge Murphy's decision makes that crystal clear. What I was expecting to hear from the relators is some discussion about how the allegations that they have made materially add to those public disclosures. And I didn't hear anything. The closest I heard was pointing to that bar chart that is up on the easel in front of the Court at the moment.

That bar chart doesn't say anything. And, in fact, when I listened to the description of what that bar chart was in bumping up data, I heard data being compared that was in car accident reports to data that private health insurance companies have, to data that was bought from ISO. What I did not hear, and this is critical to this case, is that the reports didn't make it to the Government. I didn't hear that the relators said to the Government, did you get this report. No -- and they said no. In fact, the transcript will say, the closest I heard was, I bumped up the data to Ability, whoever

that is. And Ability didn't match some other data I have.

There was nothing that the relators said to substantiate the idea that a single report didn't make it to the Government, bar chart or no bar chart.

And, in fact, there was no efforts to reconcile the ten exemplars that are appendix B to the complaint, each of which was supposedly reported to the Government. There is a coherence here, missing to this complaint.

There was a lot of discussion about lots of prior lawsuits and all the good work that relators think MSP Recovery has done. And I'm not going to get into that.

All I will say is, every other lawsuit they have filed, just like this one, is about recovering money for private health insurers. It is not about money that went to the Government. Not a single one of those lawsuits dealt with Rule 9(b). And not a single one of those lawsuits supported the theory that was here.

I was in the ACE case. My client get -- got out because these allegations were no good.

The last thing I want to say is with respect to the absence of an exemplar here, is the reference to Prather. Prather definitely is a Sixth Circuit case that allowed a relator a little more leeway than identifying a specific false claim.

Owsley, O-w-s-l-e-y, the case I discussed at length

in my main argument, read Prather and assimilated the Sixth Circuit Law on the subject. And I summarized that for you earlier today. I won't do it again.

Suffice it to say, that the failure to plead one specific example, one, is fatal to the case.

When I have argued hundreds -- dozens and dozens of 12(b)(6) motions where you say this fails to state a claim, the other side gets up, they go through your example, and they explain, I'm going to show the jury this, I'm going to show the jury that, and I'm going to show the jury the other thing. And with those three things, that establishes the elements of my cause of action. That's missing from the case. You didn't hear it during Plaintiff's argument. It's nowhere in the complaint.

Again, the defendants respectfully appreciate the Court's time. And thank you for the attention that we know you're going to give to the important matter. And I think that the Court should dismiss the case with prejudice because there's no basis for any amendment that's been suggested.

And, thank you, Your Honor.

THE COURT: Okay. Thank you.

MR. ARMAS: Judge, may I have a -- a small rebuttal?

THE COURT: No.

MR. ARMAS: Okay.

THE COURT: That seems really unfair, but --

MR. ARMAS: Judge, I promise you --

THE COURT: What is --

MR. ARMAS: -- that somehow --

THE COURT: -- the rebuttal?

MR. ARMAS: -- coming from you, it doesn't seem unfair at all.

THE COURT: Okay. What were you going to rebut?

Are you going to rebut that the offer of exemplars, or are you going to rebut, like -- tell me, have you offered an amended complaint that you filed, a further amended complaint, and so I can determine why, if you amended it, it would not be futile or something like that?

MR. ARMAS: No, Judge. No. But we have not proffered an amended complaint.

THE COURT: Don't you think you're required to do that?

MR. ARMAS: I don't believe so, Judge.

THE COURT: Okay.

MR. ARMAS: And, Judge, if I could.

When a defendant --

THE COURT: State your name again so the --

MR. ARMAS: Yes, Judge. It's Alfredo Armas.

THE COURT: Even though I said no, you still came to the podium.

Five minutes, okay? No further because you all are

exhausting your arguments.

MR. ARMAS: Judge, if I could, I want to address the point raised by the Court because that's the most important to me.

It cannot be the law that every time a defendant files a motion to dismiss, a Plaintiff must strike its tent and withdraw its complaint and proffer an amended complaint.

I -- I believe, and I submit to the Court that we have identified a massive fraud with specificity. But if the Court is not satisfied that, yes, we should be given the right to file a second amended complaint. Reminding the Court that this is the first pleading that has been disputed by -- by these insurance defendants.

THE COURT: Okay.

MR. ARMAS: Thank you.

THE COURT: Thank you, Counsel.

All right. Let's hear the other arguments.

This is for the State Farm defendants, right?

MR. BARUCH: That's right, Your Honor.

THE COURT: Okay.

MR. BARUCH: And I'll try to be brief. I know this --

THE COURT: You're not required to be brief.

MR. BARUCH: Okay. I appreciate that.

THE COURT: You're required to approach the amount of

time you've indicated that you would need, okay?

MR. BARUCH: Which I thought was brief, but that's okay.

So I'm going to address -- I'm Doug Baruch on behalf of the State Farm defendants, and I'm going to address a couple of points that are specific to State Farm.

I want to talk about --

THE COURT: Okay. Hold on one second.

MR. BARUCH: -- our efforts to get Mr. Angelo to comply with Judge Cleland's order in a separate RICO case. Our position is that Mr. Angelo has not complied with that order. And as a result, we don't know yet, whether the Government will consent to the dismissal of State Farm from this qui tam action.

And second, I want to spend a minute on State Farm's first-to-file argument.

THE COURT: State Farm's what?

MR. BARUCH: We had a -- we have a separate first-to-file argument.

THE COURT: Sure. Okay.

MR. BARUCH: So even if the action isn't dismissed pursuant to the RICO settlement, we, State Farm, believe that the state -- the False Claims Act under the first-to-file bar under 3730(b)(5) blocks the second relator, MSP WB, from pursuing any claims against State Farm.

And these -- these State Farm grounds are in addition to the arguments that apply to all -- all of the defendants, as Mr. Friedman explained. And so, if the Court dismisses the action on the public disclosure bar, or any of the other reasons applicable to all defendants, then the Court would not need to resolve the additional arguments raised by State Farm.

THE COURT: Okay. Thank you. Go ahead.

MR. BARUCH: Okay.

Now, I also want to make a very quick point about the conspiracy count that's been addressed here this afternoon. I want to emphasize that State Farm has an additional argument with respect to that claim.

With respect to the State Farm, the claim is not adequately pled, the conspiracy claim, because the claim rests on the allegation that the insurer defendants worked with Defendant ISO. And that's even more obvious given relator MSP's most recent submission, which, again, makes the supposed dealings with ISO the center of their case.

And you heard it from Mr. Armas today, he said that they all use ISO, that ISO is at the very center of the conspiracy here. But the situation's different for State Farm. State Farm did not contract with ISO.

As we pointed out in our brief, State Farm had its own system for reporting to Medicare, and it did not enter into an outside contract for those services. We made those

points in our filings at ECF 338, page ID 2017, and ECF 341, page ID 2869.

Relators did not dispute State Farm's representations in this regard. So while State Farm joins in the motion of all of the defendants here to dismiss the conspiracy count, the conspiracy claim as to the State Farm's defendants fails on this additional core defect, unchallenged fact that State Farm did not contract with ISO.

So let me start by talking about the -- the enforcement of the RICO settlement agreement between State Farm and Mr. Angelo.

So a little bit of background first. State Farm and the original relator here, Mr. Angelo, were in litigation before Mr. Angelo filed his qui tam action. State Farm had filed a RICO action against Mr. Angelo and his companies. And that RICO case is in this District Court before Judge Cleland.

So before -- before the qui tam case was unsealed, State Farm and Mr. Angelo settled that RICO case. And one of Mr. Angelo's many obligations under the RICO settlement was that he had to talk all actions necessary to discontinue any other litigation he had against State Farm. And when State Farm later found out about this qui tam action, which had been under seal at the time, State Farm moved to enforce the settlement agreement and have Mr. Angelo take the steps necessary to dismiss this qui tam action. And State Farm

filed that action, that motion in front of Judge Cleland because he retained jurisdiction under the settlement agreement. And Mr. -- and Judge Cleland granted that motion to enforce. He granted it twice. And he held that the qui tam action, this qui tam action against State Farm, fell within the scope of the agreement, the settlement agreement, for purposes of Mr. Angelo's dismissal obligations. And he ordered Mr. Angelo to take steps to discontinue the actions, including by seeking the Government's consent to dismissal, and to take no contrary or inconsistent acts.

State Farm's position is that Mr. Angelo has not complied with that order. He's not properly sought the Government's consent for Mr. Angelo to voluntarily dismiss the qui tam action as to State Farm. And we don't know, because of that, whether the Government will consent. And because of this noncompliance, we filed yet another motion, a second motion to enforce before Judge Cleland. And that motion is pending.

But our ask here is simple. We want Mr. Angelo to file a notice of voluntary dismissal as to State Farm in this case. And once he makes that filing, the Government will either consent in writing to the dismissal, or it won't.

So the Government hasn't had to make that election yet because Mr. Angelo has never asked it to do that.

THE COURT: What's the nature of the -- is the

current nature of the suit before Judge Cleland a motion to enforce it, or some other thing, like a motion for contempt or something?

MR. BARUCH: We -- we filed a second motion to enforce.

THE COURT: Okay. Okay.

MR. BARUCH: We have not filed a motion for contempt.

THE COURT: All right. Go ahead.

MR. BARUCH: Okay.

THE COURT: Anything else on that?

MR. BARUCH: Okay.

And then, I do want to just spend a minute on the first-to-file argument. And we briefed -- we briefed that bar and how it applies, and how it should prevent the MSP relators' attempt to insert itself, and to Mr. Angelo's pending qui tam.

But let me just take a minute because there's been an intervening decision by Judge Murphy, and he made an assessment of the first-to-file argument made in the Allstate case that came out after the briefing in this -- on the motion to dismiss here, was disclosed.

And so, respectfully, we think Judge Murphy in that limited instance, his interpretation of Section 3730(b)(5) was wrong. Judge Murphy said that he was relying on the plain text of the statute by reading the word "intervention" in

3730(b)(5), as referring only to a Rule 24 intervention, and not a relator edition by Rule 15 amendment.

But if we actually look at the use of the word "intervene" in the False Claims Act statute, we find that it's used -- it's used several times, three times in the statute. And in all -- in all instances when it's used, it's referring to the Government's intervention and decidedly, not a Rule 24 intervention.

Government intervention under the False Claims Act is unique. It's not -- they're not subject to the criteria of Rule 24.

And the point is, that within the False Claims Act, we believe, and it shows clearly that Congress did not equate intervention, I want to use that term in the False Claims Act, with a Rule 24 intervention.

In addition, the Sixth Circuit hasn't addressed this specific exact situation here, but it has been very clear, and it's in the Walburn case that's been discussed this afternoon. The Sixth Circuit has made clear that the first-to-file bar unambiguously prevents successive plaintiffs from bringing related actions.

So it's clear that if -- if MSP WB, the new relator here, had filed a separate qui tam action, it would clearly be barred. So here, MSP is still a successive relator in this context, is trying to come into this suit after Mr. Angelo

already filed suit, and allowing it to intervene here through an amendment, would just be really circumventing or an end run around the unambiguous statutory bar.

And finally, on this point, when Mr. Angelo filed the amended complaint against State Farm in June of 2021, we believe that he was violating his obligation under the RICO settlement agreement. As we talked about a couple of times already, Judge Cleland already has held that the RICO settlement agreement -- excuse me, required Mr. Angelo to take all actions necessary to dismiss the qui tam action. And he said that Mr. Angelo could undertake no contrary or inconsistent acts until he complied with that obligation. And as a result, he was not permitted to -- to file the amended complaint which introduced MSP WB into this action.

If the Court has no further questions, or no questions, I will submit.

THE COURT: Okay. Thank you, very much.

I don't have any questions at the time.

MR. BARUCH: Okay. Thank you.

MR. AKEEL: Good afternoon, Your Honor. Shereef Akeel on behalf of the relators.

THE COURT: Good afternoon. You may proceed.

MR. AKEEL: Thank you. Thank you, Judge.

Your Honor, I'm responding with respect to the private litigation that involved relator Michael Angelo, with

State Farm, in a separate no-fault RICO action regarding payment, wrongful payment of no-fault benefits involving car accidents.

In -- in that matter, the RICO complaint was filed by State Farm March 6, 2019. No government claims were involved. No -- no issues involving Medicare or Medicaid. It was purely involving breach of a contract or a wrongful payment based on policies involving insurance.

On July 24, 2019, the qui tam complaint -- the qui tam matter was filed under seal after Mr. Michael Angelo discovered fraud being perpetrated by State Farm against the United States.

On March 2, 2021, while the matter was still being -- was still under seal, the RICO matter was settled. State Farm was not aware, or could they be aware of any government claims. The relator would violate or breach the seal if he discloses the fraud that was reported to the United States.

April 6, 2021, this matter was unsealed. State Farm became aware of the govern -- the claim -- the fraudulent claims against the Government, and they tried to -- well, they filed a motion claiming that the settlement agreement that they entered into includes government claims, Medicare claims. We objected.

We cited also, Bedrock Law, Sixth Circuit Law, that a relator is prohibited from entering into any agreement to

release a qui tam action when -- after it's been filed.

So a release cannot be entered into to release government claims while the matter is pending, without the consent of the Government.

We cited the law, U.S. Health Possibilities, 207 F.3d 335.

There was also other arguments why the matter was not within the scope of this private settlement agreement. That matter is pending before the Sixth Circuit. We filed the Notice of Appeal. Nevertheless, Judge Cleland provided Michael Angelo a deadline. By May 16, 2022 -- well, let me back track.

First, Judge Cleland agreed that Mr. Angelo cannot dismiss -- agreed with Mr. Michael Angelo, that the Government claims cannot be dismissed as how State Farm was seeking it originally. Judge Cleland said specifically, I'm providing a deadline for Mr. Michael Angelo by May 16, 2022, to simply ask the Government. That was ECF 149, 22822 order, ECF 149, page 15.

On May -- this is now a subsequent development after the briefs have been filed here. On May 16, I contacted the Government to advise them of Judge Cleland's order to seek consent to dismiss. The Government responded by stating, one, Angelo has no authority to release the Government claims; and two, Government maintains the same position in allowing for

the prosecution of the qui tam claims against State Farm.

I filed a declaration in the Cleland matter, ECF 162, 8327. I also memorialized the conversation and attached an e-mail with the Government, ECF 165-4, page ID 8401.

A month later, on June 16 -- a month later on June 16 -- so we thought that was the end of the story, that's it. We had an issue that -- of the interpretation of the settlement agreement. I contacted the Government saying, hey, there is -- State Farm is still -- here's this order, this is what we're being asked to do. Thought that was it after we filed the declaration.

A month later, State Farm filed a new motion. It's an untimely motion, June 16, 2022. Now, they are seeking for Mr. Michael Angelo to file a motion for voluntary dismissal, which is different than what the judge asked Mr. Michael Angelo to do, which was to simply ask.

Here, they're asking for a motion to be filed, which is, again, contrary to Sixth Circuit Law that the Government claims are not enforceable within the context of a release that's entered by a relator if -- while a qui tam action is pending.

That matter is pending, and it's really -- it's disguised as a motion to enforce, but it's really a motion to try to amend the order to try. And that matter is pending right now.

Also, what is being lost here, is we have a co-relator, MSP. MSP has not been haled into court with Judge Cleland, has not been involved, at all, in this private RICO matter. It's totally separate. It has its own rights. This matter involving Mr. Angelo is a persona matter involving his individual claims.

So we have a co-relator. We have due process rights here. Because the co-relator, MSP is also -- as its acting as an agent for the Government here, and is not bound by any State Farm, and does not -- by any State Farm agreement, and does not wish, of course, to dismiss, but to continue prosecuting the claims against the Government.

THE COURT: Okay. Mr. Akeel, adjust your mask a little bit.

MR. AKEEL: Sorry. It's, like, choking me.

THE COURT: Okay. I understand. But adjust it to keep it up, okay?

MR. AKEEL: Okay. I will. I'm trying to breathe through it.

Your Honor, regarding the first-to-file bar argument, we rely on the brief that we pled in, and also, the established law that an amendment is proper through Rule 15.

A co-relator can enter into an agreement with a relator if they have a private agreement. This is not a parasitic lawsuit. This is not a new lawsuit. It's

contemplated. There's case law, a plethora of case law that supports that. Judge Murphy also has ruled that the first-to bar is not violated. That's ECF 102, 2954.

Oh, one -- one other argument, Your Honor, regarding the particular fraud.

Brother Counsel indicates that State Farm has a unique situation here, that they do not use ISO. Actually, they do. Actually, they admitted that they do. That's at 3351968.

Importantly, contrary to what I've heard today where they're trying to kind of downplay the significance of ISO like it's a BroadSpire or Fugit, ISO is essentially the central hub. It's a Clearinghouse, we've pled that, for the entire insurance industry. It has over 660 million claims. It has a history of every single claim that's filed in the United States.

So if someone with Progressive in 1990 files a claim, then he's with Auto Club in 2020, they'll be able to track him. That's a very vital source for the insurance companies to determine the history of a -- of a claimant. And ISO has been delegated with a responsibility to file, to be the mouthpiece to the Government, and file proper reports.

Likewise, the roles here are reversed. State Farm uses ISO data to file whatever they need to file. Because the roles have shifted here, where ISO is not the one that's

filing the direct report for the insurance company, I mean, like they do for the rest of the insurance company.

State Farm uses ISO data, and ISO does not have the required data, including the social security numbers, which is a very simple thing to ask of insureds. So Medicare is able to match the social security number of a Medicare recipient with the social security number with a claimant. Once that's a match, then it triggers the Government's ability to send a notice to the primary payer saying, hey, give us back the money because there's that lack of information, simple things as a social security number.

And that goes to that definition that Counsel had indicated about the fraud. It's the -- under the fraudulent -- under the U.S.C., 3721(a)(9)(G), knowingly is defined to include a person who has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, who acts in reckless disregard of the truth or falsity of the information. And, requires no proof of specific intent to defraud.

You heard the Prather, reckless disregards language, provides liability to defendant -- to a defendant who buries their head in the sand. That's Prather, 892.

Burying their head in the sand, not asking for the social security number when a claim is filed. They ask for everything else except the social security number. Then, they

file the Section 111 report, doesn't include the social security number, CMS does not have it, it can't match, does not know about the accident, cannot seek reimbursement.

There was some -- again, the downplay regarding ISO. ISO, because of its role, and because MSP had discovered this massive fraud and kicked out MSP as indicated before, ISO has never been implicated. There was no prior news article. No prior lawsuit involving ISO. This is the first time that ISO has been implicated and accused for the massive fraud here.

And this was all given and furnished to the Government before this -- the matter was unsealed. We also filed a notice. We filed a notice. It's part of the record, of the information that we had furnished to the Government. And I'll get you the cite.

Yeah, 379 is the notice of supplement that we filed with the record. I know this case went from one judge to another, and I understand so some things could get lost, but 379 demonstrates the -- it includes in my declaration, what was furnished to the Government before this matter was unsealed. It includes a memo. And a memo demonstrates how all the data was tied together to demonstrate to the Government, this massive fraud that occurred.

And this, again, Your Honor, goes to first of all, we cleared the public disclosure. ISO was never disclosed. We're done with that. But if there is an argument that there

is a public disclosure, which there shouldn't be because there's nothing -- you can't say anything about ISO, the original source kicks in.

Did we materially add to publicly available with the significant role by ISO in being the mouthpiece for the entire insurance industry in filing these regular quarterly CMS reports? The answer is yes.

For those reasons, Your Honor, we ask that the dismissal would be denied.

Thank you.

THE COURT: Okay. Thank you.

Do you have rebuttal?

MR. BARUCH: Yes, Your Honor. I need 30 seconds.

THE COURT: No lawyer ever speaks for 30 seconds.

MR. BARUCH: I'm going to do it.

So very, very briefly just on the very first point. Our position is, relator did not properly seek the Government's consent. The proper way to seek the Government's consent is to file a motion for voluntary dismissal. The statute provides that the Government -- that the Attorney General has to consent in writing.

Why are we guessing at what the Government's position is here? It's very simple. They should file a motion. The Government will either consent in writing or withhold its consent in writing. Then, we'll know.

Thank you.

THE COURT: Okay. Anything else from anyone else? No? Okay. Then, thank you for your arguments, and I will give you a written order.

We will put ourselves on notice to see if Judge Cleland enters any further order. But if you become aware of it and it does not seem like we've noticed, please notify us that an order has been filed, all right?

MR. BARUCH: Yes, Your Honor.

THE COURT: Okay. Thank you for your arguments. And I'll give you a written order, like I said.

And, court is in recess, and have a good evening.

CASE MANAGER: All rise.

THE COURT: One question, this chart is at the end of the complaint, or at the end of your --

MR. SUSMAN: It's at the end of the complaint.

THE COURT: Okay. I'm aware of that. So it's in that section?

MR. SUSMAN: Yes.

THE COURT: Okay. All right. Thank you, very much. So court is in recess.

(The proceeding was concluded at 4:44 p.m.)

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C E R T I F I C A T E

I certify that the foregoing is a correct transcription of the record of proceedings in the above-entitled matter.

S/ Shacara V. Mapp 12/16/2022

Shacara V. Mapp, Date

CSR-9305, RMR, FCRR, CRR

Official Court Reporter